CMS-1500 Basics and 5010 Compliance Update for Billing

Presented by TMA UBO Program Office Contract Support

Dates and Times:

13 December 2011 0800-0900 EST

15 December 2011 1400-1500 EST

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Objectives

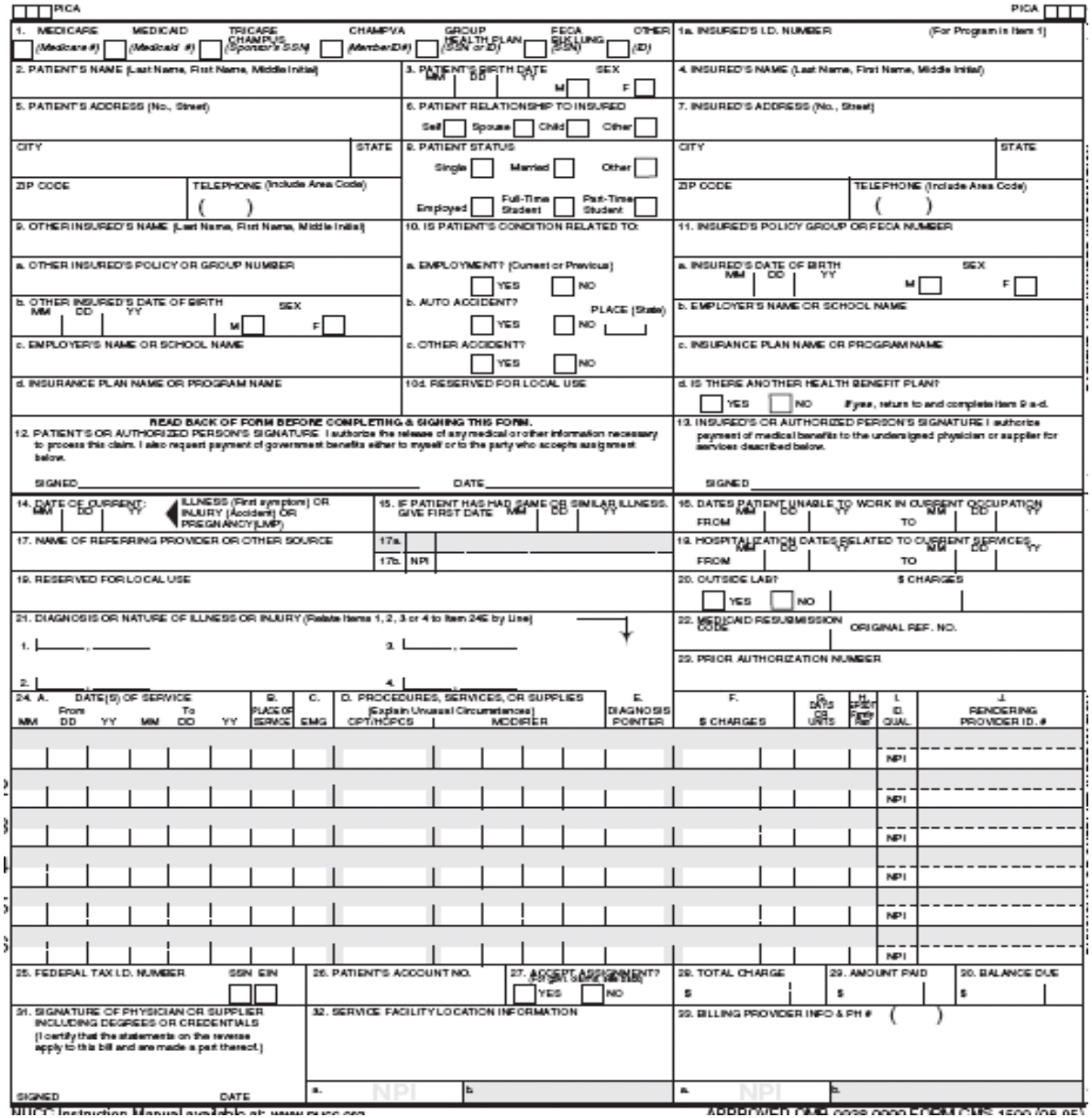
- Understand the data elements necessary for claims submission for professional services on form CMS-1500 (08/05)
- Know which data elements are required and which are situational
- Review the NUCC July 2011 version 7.0 instruction updates which include the HIPAA X12 5010A1 transaction requirements that apply to electronic claims only

Source and Effective Date

- Form CMS-1500 and its Reference Instruction Manual version 7.0 (July 2011) are published and updated by the National Uniform Claim Committee (NUCC). They are available at: http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42/

- Instructions for Version 5010A1 of the HIPAA transaction requirements for billing professional claims in this presentation are effective 1 January 2012 and apply to electronic claims only

CMS-1500 Claim Form (08/05)



PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Patient and Insured Information

Item 1: Required
Type of Health Insurance Coverage
[Insurance coverage]

Item 1a: Required
Insured's ID Number
[This information identifies the insured to the payer]

Item 2: Required
Patient's Name (last name, first name, and middle initial)
[Name of the person who received the treatment/supplies]

Item 3: Required
Patient Birth date
[Eight-digit birth date (MM|DD|CCYY) of the patient]

Patient and Insured Information

Item 3 *(cont'd)*: Required
Patient's Sex
[Patient's gender]

Item 4: Required
Insured's Name (Last Name, First Name, Middle Initial)
[Insured's name identifies the person who holds the policy]
5010A1 Instructions: If the patient can be identified by a unique member identification number, the patient is considered to be the "insured".

Item 5: Required
Patient's Address

First line	–	street address
Second line	–	city and state
Third line	–	ZIP code and phone number

5010A1 Instructions: "Patient's telephone" does not exist; NUCC recommends telephone number not be reported.

Patient and Insured Information

Item 6: Required
Patient's Relationship to Insured
"Self" – indicates the insured is the patient
"Spouse" – indicates the patient is the husband/wife or qualified partner as defined by the insured's plan
"Child" – indicates that the patient is the minor dependent as defined by the insured's plan
"Other" – indicates that the patient is other than the self, spouse or child
(could include – employee, ward or dependent as defined by the insured's plan)

5010A1 Instructions: If the patient is a dependent, but has a unique Member ID number and the payer requires the identification number to be reported on the claim, then report "Self", since the patient is reported as the insured.

Patient and Insured Information

Item 7: Required, if applicable
Insured's Address
[Mailing address and telephone number of the insured in the corresponding box. If Item 4 is completed, then this field should be completed]
5010A1 Instructions: "Insured's Telephone" does not exist in 5010A1; the NUCC recommends that the phone number not be reported.

Item 8:
Patient Status
[Marital status and full- or part-time student]
5010A1 Instructions: "Patient Status" does not exist in the 5010A1; the NUCC recommends that this field not be used.

Patient and Insured Information

Item 9: Required, if applicable
Other Insured's Name
[Indicates that there is a holder of another policy that may cover the patient.
When additional group health coverage exists, enter other insured's full last name, first name, middle initial of the enrollee in another health plan IF it is different from that shown in Item 2.]

Item 9a: Required, if applicable
Other Insured's Policy or Group Number
[Other insured's insurance policy or group number]

Patient and Insured Information

Item 9b:
Other Insured's Date of Birth/Sex
[Eight-digit date of birth (MM|DD|CCYY). Check the appropriate box indicating the sex of this person]
5010A1 Instruction: does not exist in 5010A1; NUCC recommends that this field not be used.

Item 9c: Required, if applicable
Employer's Name or School Name
5010A1 Instruction: does not exist in 5010A1; NUCC recommends that this field not be used.

Item 9d: Required, if applicable
Insurance Plan Name or Program Name
[Enter the other insured's insurance or program name]

Patient and Insured Information

Item 10a-10c: Required, if applicable
Is Patient's Condition Related To: (Employment, Auto Accident/Other Accident)
[Check the appropriate box if the patient's condition is related to any of the following: employment, auto accident, or other accident]

Item 10b: Required, if applicable
State Postal code
[If "YES" is marked for auto accident, the state postal code where the accident occurred must be reported. "Yes" indicates that there may be other applicable insurance coverage that would be primary. Note: primary insurance information must be shown in Item 11]

Item 10d: Not Required
Reserved For Local Use
[Leave blank]

Patient and Insured Information

Item 11: Required, if Applicable
Insured's Policy, Group, or FECA Number
[Refers to the alphanumeric identifier for the health, auto or other insurance plan coverage. Enter the insured's policy or group number as it appears on the insured's health care ID card]

Item 11a: Required
Insured's Date of Birth/Sex
[Eight-digit date of birth (MM|DD|CCYY); check the appropriate box indicating the sex of the insured]

Patient and Insured Information

Item 11b: Conditional
Employer's Name or School Name
[Insured's employer's or school name]
5010A1 Instruction: does not exist in 5010A1; NUCC recommends that this field not be used.

Item 11c: Required
Insurance Plan Name or Program Name
[Name of the insured's insurance plan or program]

Item 11d: Required, if applicable
Is There Another Health Plan Benefit?
[Check the appropriate box to indicate whether or not there is another health insurance benefit. If 'YES' is checked, Items 9–9d must be completed.]

Patient and Insured Information

Item 12: Required with a default (“Signature on file” is acceptable)
Patient’s or Authorized Person’s Signature

Item 13: Required with a default (“Signature on file” is acceptable)
Insured’s Authorized Person’s Signature

Provider or Supplier Information

Item 14: Required, if applicable
Date of Current Illness, Injury, or Pregnancy
[Current date of illness, injury or pregnancy (MM|DD|CCYY). Refers to the first date of onset of illness, the actual date of injury, or the LMP (last menstrual period) for pregnancy]

Item 15: Required, if applicable
If Patient Has Had Same or Similar Illness
[Past occurrence date (MM|DD|CCYY) of illness or injury if it is the same or similar illness or injury. Note: previous pregnancies are not a similar illness. Leave blank if unknown]
5010A1 Instruction: does not exist in 5010A1; NUCC recommends that this field not be used.

Provider or Supplier Information

Item 16: Not Required
Dates Patient Unable to Work in Current Occupation
[Leave blank]

Item 17: Conditional
Name of Referring Provider or Other Source
[Name of the provider who referred or ordered the service]

Provider or Supplier Information

Item 17a: Required
Other ID # of the referring, ordering or supervising provider
[The primary HIPAA taxonomy code associated with the provider specialty table will be reported for the referring provider, ordering or other source]

Item 17b: Required
Provider NPI #
[NPI Type1 of the referring, ordering or supervising provider]

Item 18: Required, if applicable
Hospitalization Date Related to Current Services
[Eight-digit date (MM|DD|CCYY) if the services were provided subsequent to a related hospitalization]

Provider or Supplier Information

Item 19: Not Required
Reserved for Local Use
[Leave blank]

Item 20: Not Required
Outside Lab
[Leave blank]

Item 21: Required
Diagnosis or Nature of Illness or Injury
Enter the ICD-9-CM diagnosis code(s) for the patient's diagnosis/condition. List no more than 4 ICD-9 CM Diagnosis codes.
Relate lterns 1, 2, 3, and 4 to the lines of service in Item 24e

Provider or Supplier Information

Item 22: Not Required
Medicaid Resubmission
[Leave blank]

Item 23: Required, if applicable
Prior Authorization Number
[Prior authorization number for those procedures requiring prior authorization such as referral number, mammography pre-certification number, as assigned by the Payer for the current service]

Section 24 Required
[The six service lines in Item 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service]

Provider or Supplier Information

Section 24a: Required
Dates of Service
[Enter both the “From” and “To” dates. If only one date of service, enter that date and re-enter same date. Note: the number of days must correspond to the number of units in Item 24G]

Item 24b: Required
Place of Service
[Code “26” represents an MTF. This code should automatically print on all CMS-1500s. However for an emergency room visit, the place of service will be coded as "23" Emergency Room.]

Provider or Supplier Information

Item 24c: Required, if applicable
EMG – Emergency Indicator.
[The indicator states whether or not the service is related to an emergency.]

Item 24d: Required
Procedures, Services, or Supplies
[HCPCS/CPT code, including modifiers when applicable, for the procedures, services, or supplies furnished to the patient]

Provider or Supplier Information

Item 24e:
Diagnosis Pointer
[Pointer number (1–4) from Item 21 that is applicable to that specific procedure, service, or supply furnished. Do not use commas between the numbers.]

Item 24f: Required
Charges
[Refers to the total billed amount for each service line. Do not enter dollar signs.]

Provider or Supplier Information

Item 24g: Required
Days or Units
[Number of days or units that were supplied for that particular HCPCS/CPT code listed in that line. If only one service was provided, the numeral 1 must be entered.]

Item 24h: Not Required
EPSD/ Family Plan
[Leave blank]

Item 24i: Required
ID Qualifier
[The ID qualifier will default to (**PX- Provider Taxonomy)** and will be used to report the type of non-NPI number of the rendering provider. The Provider Taxonomy code of the rendering provider will be reported in the shaded area of Item 24j]

Provider or Supplier Information

Item 24j: Required
Rendering Provider ID#
[The Provider Taxonomy code of the rendering provider will be reported in
the shaded area. NPI Type 1 of the rendering provider will be reported in the unshaded area.]

Item 25: Required
Federal Tax ID Number

Item 26: Required
Patient's Account Number
[Patient's account number that is assigned by the MTF's accounting system to identify that particular patient. No hyphens.]

Provider or Supplier Information

Item 27: Required
Accept Assignment

Item 28: Required
Total Charge
[Total charges for the services provided (e.g., sum of charges in Item 24F)]

Item 29: Conditional
Amount Paid
[$0.00 indicates no up-front monies were paid. DoD does not collect
co-payments for services rendered]

Provider or Supplier Information

Item 30: Conditional
Balance Due
[Total amount of the charges. This should match Item 28]

Item 31: Required
Signature of Physician or Supplier
[Signature of the provider of service or supplier, or his representative, and the date the form was signed. A signature or stamp is required here]

Item 32: Required-
Treating Service Facility
[Name and Address of Facility Where Services Were Rendered
Name, address, and telephone number of the MTF]
5010A1 Instructions: Report a 9 digit zip code; include the hyphen.

Provider or Supplier Information

Item 32a: Required
NPI Number of where the services were rendered.
[NPI Type 2 of the treating MTF will be reported in this field]

Item 32b: Required
Other ID Qualifier and Other ID#
[The qualifier will be reported followed by the HIPAA Taxonomy code or Treating Facility Tax ID]

Item 33: Required
Billing Provider Information and phone number
[Name of the physician who rendered the services.
Enter the provider name, address, zip code and phone number.
5010A1 Instruction: Must be a street address or physical location. Use 9-digit ZIP-include the hyphen.

Provider or Supplier Information

Item 33a: Required
NPI Number of the Billing Provider
[NPI Type 2 of the billing facility will be reported]

Item 33b: Required
Other ID#
[The qualifier followed by the HIPAA Taxonomy or Billing Facility Tax ID will be reported]
5010A1 Instructions: two digit qualifier identifies the non-NPI number followed by the ID number. Examples include:

OB – State License Number
G2 – Provider Commercial Number
ZZ – Provider Taxonomy

Summary

- We have reviewed the data elements necessary for correct professional claims submissions on the CMS-1500 (08/05) form
- We know why these are required
- We know which ones are required on the form vs. situational
- We have covered the NUCC July 2011 version 7.0 instruction updates for billing professional services which include the HIPAA X12 5010A1 transaction requirements that apply to electronic claims only

Questions

- Thank you for attending this Webinar.

- If you have any questions please direct them to the UBO.Helpdesk@Altarum.org.

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